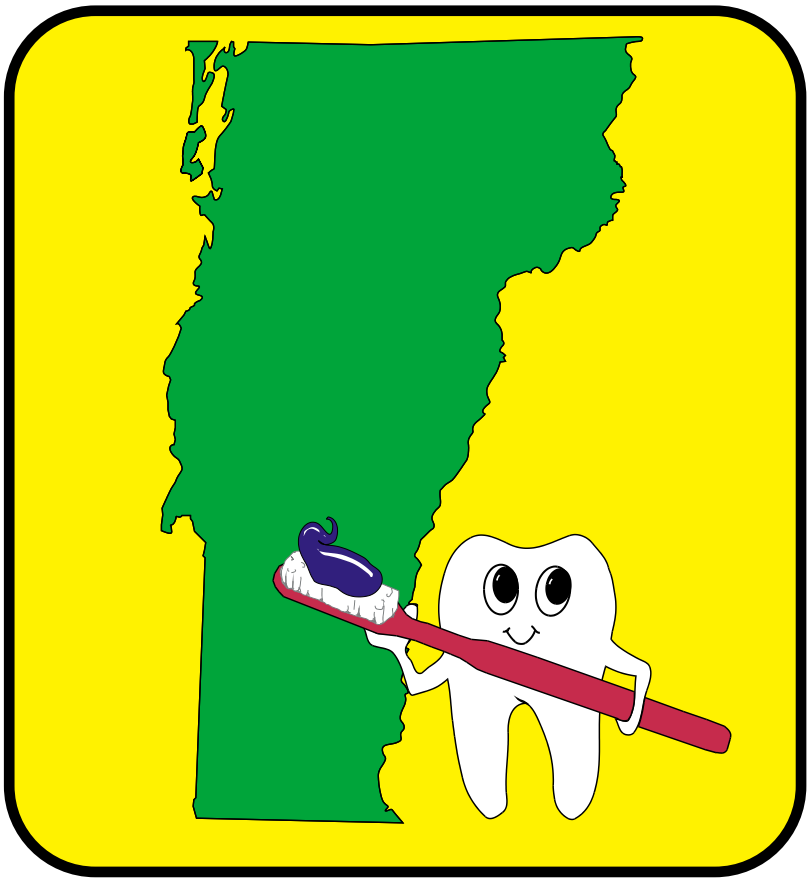

Vermont State Employee Dental Assistance Plan

State of Vermont
Employee Benefits and Wellness Division

Effective July 2001
(Revised for New Procedure Coding)

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How Your Dental Assistance Plan Works

The Vermont State Employee Dental Assistance Plan has been designed to help you to pay dental bills for yourself and your eligible family members.

No deductible

Deductible amount - $25 per plan year/$75 maximum deductible per family

Preventive/Diagnostic Coverage A Services	Basic Coverage B Services	Major Coverage C Services	Orthodontia Coverage D Services
Diagnostic: Initial evaluation Periodic evaluation, 2 in 12 months. X-rays- bitewings 2 in 12 months, Complete series/Panoramic film every 3 years Tests and laboratory examinations Emergency treatment *Preventive*: Cleaning of teeth, 2 per 12 months Fluoride treatment, 1 every 12 months, to 19th birthday Space maintainers Sealants, permanent posterior teeth only, once every 3 years to age 14	Anesthesia Fillings Amalgam Silicate Acrylic Root canal Gum treatments Oral surgery Maintenance of fixed partial dentures and dentures	Gold foil fillings Inlays Crowns Installation of fixed partial dentures and dentures	Straightening of teeth
Payable at 100% of the usual, customary and reasonable charge. Employee pays balance if any.	**Payable at amounts shown in the Schedule of Dental Services. Employee pays balance.**	**Payable at amounts shown in the Schedule of Dental Services. Employee pays balance.**	**Payable at amounts shown in the Schedule of Dental Services. Employee pays balance.**

Maximum amount per plan year - $1,000

Lifetime maximum amount - $1,750

SUMMARY OF BENEFITS

COVERAGE A DENTAL SERVICES are **DIAGNOSTIC AND PREVENTIVE** services, as listed in the chart on the prior page. These charges are paid at 100% of the usual, customary, and reasonable charge. There is no annual deductible for these services. If your dentist charges more than the usual and customary fee, you must pay any balance.

COVERAGE B, C AND D DENTAL SERVICES are **BASIC, MAJOR AND ORTHODONTIA** services, as listed in the chart on the prior page. These are paid up to the amount shown in the Schedule of Dental Services beginning on page 8. The Plan Year deductible applies to these services.

PLAN YEAR DEDUCTIBLE:
The deductible applies to both the dental and orthodontia benefits.

Per individual	$25
Per family	$75

MAXIMUM PLAN YEAR BENEFITS: Each covered individual may receive up to $1,000 in dental benefits in a plan year. This does not include Coverage D (Orthodontia) Dental Services.

The Plan Year is the State's fiscal year, from July 1 of one year to June 30 of the next .

MAXIMUM LIFETIME ORTHODONTIA BENEFIT: The lifetime maximum benefit for each covered individual is $1,750. This is a separate benefit from the dental benefit. Orthodontia charges do not add into the yearly maximum dental benefit.

USUAL, CUSTOMARY, AND REASONABLE FEES:

- ***Usual:*** A usual fee is the fee regularly charged and received for a given service by a Participating Dentist.
- ***Customary:*** A fee is customary when it is in the range of usual fees charged by Vermont Dentists.
- ***Reasonable:*** A fee is reasonable when it is usual and customary and is justifiable considering the circumstances of the particular case in question as determined by the Plan Administrator.

ELIGIBILITY INFORMATION

WHO IS ELIGIBLE FOR BENEFITS?

The benefits described in this booklet are provided at no cost to you by the State of Vermont. You and your eligible dependents are covered as soon as you have completed six months of continuous State employment. To be eligible, you must be a permanent full-time employee or a permanent part-time employee regularly working 15 or more hours a week. Temporary and contractual employees are not eligible.

WHO ARE ELIGIBLE FAMILY MEMBERS?

Dependents are your spouse as long as you are not legally separated or divorced; your bona fide domestic partner; and each of your single children, up to age 19, or if they are full-time students, up to age 23. Single children include: step children, foster children, legally adopted children and children of your domestic partner, as long as you are financially responsible for them.

Benefits for any of your unmarried children who are mentally or physically incapable of earning their own living may be continued beyond the above age limits. To do so, you must submit proof of your child's incapacity directly to the Director of Employee Benefits and Wellness. This must be done within 31 days after the coverage would otherwise end.

Your dependents who are also State employees will be covered as employees rather than as your dependents.

HOW TO JOIN THE PLAN OR ADD/DELETE DEPENDENTS:

The State will notify the claims administrator as soon as you become eligible. You will be sent a plan booklet and an I.D. card at that time. To add or delete eligible dependents, you must contact your Personnel Officer for a State of Vermont Enrollment/Change Application ("Payroll Form").

WHEN COVERAGE BEGINS:

Coverage for you and your eligible dependents begins the day you complete six months of continuous service. If you are not actively at work on that day, coverage will not begin until you return to work for one full day.

WHEN COVERAGE ENDS:
Coverage for you and/or your eligible dependent will end:

- At the end of the bi-weekly pay period during which you end employment;
- For dependent children, at the end of the bi-weekly pay period in which:
    1. They reach their 19th birthday, unless they are a full-time student, or
    2. If a full-time student, they graduate or reach their 23rd birthday, whichever is earlier.
- When you or your dependent are no longer eligible as explained on Page 4; or
- When the group policy terminates.

LEAVES OF ABSENCE:
If you stop work because of reduction in force (RIF) or leave of absence without pay, coverage for you and your eligible dependents will continue automatically for four pay periods (approximately two months), after the pay period during which you stopped work. At the end of that time, you may sign up under COBRA and continue your coverage by paying 102% of the premium. See your Personnel Officer for further details.

When you return to work you will be covered on the day you return, if you return within two years.

EXTENSION OF BENEFITS:
You will be covered for certain dental services for up to three months after your coverage ends if the service began before your coverage ended. A service is considered to begin:

- On the date the final impression is made for an appliance or modification of one. However, this does not apply to Coverage D (Orthodontia) dental services;
- On the date the teeth are actually prepared for a crown, bridge or gold restoration;
- On the date the pulp chamber is opened for root canal therapy.

All other services begin the date the complete service is actually performed.

COBRA:

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986) is a federal law. It allows employees and/or their dependents to continue dental coverage after it would normally end for any of the following reasons: job termination, reduction in force (RIF), death, divorce or dependents reaching the Plan's limiting age (which makes them ineligible for coverage). **Please note that COBRA does not apply to domestic partners or children of domestic partners because they are not considered legal dependents under the governing rules and regulations of the Internal Revenue Service**. Coverage may be continued for up to 18 or 36 months, depending on the reason your coverage is ending.

OPTIONS UNDER COBRA:

- **Termination or Reduction in Force (RIF):**
  You can elect to continue coverage for up to 18 months for yourself and your covered dependents.
- **When a Child Reaches the Plan's Age Limit:**
  Coverage can be continued for up to 36 months.
- **Divorce or Employee's Death:**
  In the event of divorce or death of the employee, the divorced spouse or any covered dependent who survives the deceased employee can elect to continue coverage for up to 36 months.
- **At Retirement:**
  Under federal law, COBRA coverage ends when a person becomes eligible for Medicare.

Coverage under COBRA may be continued by paying 102% of the dental premium. See your Personnel Officer for cost and details.

COVERED DENTAL EXPENSES

Covered dental expenses are costs incurred by you or your eligible dependents for charges made by a dentist for any dental service provided by the plan, if the dental service:

- Is performed by or under the direction of a dentist; and
- Is essential for the necessary care of the teeth; and
- Begins while you or your eligible dependent is covered for dental benefits.

The term "dentist" means an individual who is duly licensed to practice dentistry in the state where the dental service is performed and who is operating within the scope of his or her license. A physician will be considered to be a dentist when he or she performs any of the dental services described in the Schedule of Dental Services and is operating within the scope of his or her license.

MAXIMUM BENEFIT:

- For Coverage A, B, and C dental services, the yearly maximum payable for each individual is $1,000. Orthodontia services are not included in this amount.
- For Coverage D dental services, (Orthodontia), the lifetime maximum payable for each individual is $1,750.

The Schedule of Dental Services contains the complete list of all covered dental services. It can be found beginning on Page 8.

DEDUCTIBLE:

There is no deductible for Coverage A Diagnostic and Preventive services. For all other services, you must pay a $25 deductible each year before the plan pays benefits. However, there is a maximum of $75, per family, per year. When three or more family members incur covered dental expenses during the same plan year and the combined expenses used toward satisfying their individual deductibles total $75, no further deductible amounts are required for the plan year. Also, any covered dental expenses incurred during April, May or June that are used to meet a deductible for the plan year ending June 30, will also be used to satisfy the deductible for the next plan year.

PRETREATMENT REVIEW

Pretreatment review is review by the claims administrator of a dentist's statement, including diagnostic x-rays, describing the planned treatment and expected charges. The system is designed to give you and your dentist a better understanding of the covered expenses payable under this plan before the services are provided. When charges for a proposed dental service or a series of dental services are expected to exceed $250, your dentist should submit a claim form to the claims administrator showing the treatment plan and fees. The claims administrator will then use this pretreatment review to determine the benefits which will be payable for each dental service according to the terms of this dental plan and notify your dentist accordingly. When the treatment plan is finished, your dentist will resubmit the claim form for payment showing the date each service was performed.

Failure to comply with the pretreatment review process will not invalidate a claim. However, the possibility of any misunderstanding will be greatly reduced if both you and your dentist understand beforehand exactly which services are covered and what benefits will be paid.

SCHEDULE OF DENTAL SERVICES

The following schedule lists all of the services covered under the plan. Any dental service not provided in this list will not be covered unless the Plan Administrator reviews the service and determines it to be appropriate.

Benefit payments are made after the service is performed. Services must be performed before payment can be made.

NOTE: A word about plan benefits for cleanings, evaluations and certain x-rays. The plan does ***NOT*** provide two such services each plan year. It allows "not more than two in a consecutive twelve month period." You cannot have your third paid for if it is earlier than twelve months after your first. For example: You had your first cleaning in October, your second in March. If your third is done in August or September, ***it is not covered.*** It must be done in October or later.

Procedure Codes Covered by
The Vermont State Employee Dental Assistance Plan
Effective July 1, 2001

COVERAGE A: DIAGNOSTIC & PREVENTIVE

These services are paid based on the Usual, Customary and Reasonable (UCR) charge.

DIAGNOSTIC

0120	periodic oral evaluation	UCR
0140	limited oral evaluation – problem focused	UCR
0150	comprehensive oral evaluation	UCR
0170	re-evaluation–limited, problem focused (established patient; not post–operative visit)	UCR
0210	intraoral – complete series (including bitewings)	UCR
0220	intraoral – periapical – first film	UCR
0230	intraoral – periapical – each additional film	UCR
0240	intraoral – occlusal film	UCR
0250	extraoral – first film	UCR
0260	extraoral – each additional film	UCR
0270	bitewing – single film	UCR
0272	bitewings – two films	UCR
0274	bitewings – four films	UCR
0277	vertical bitewings – 7 to 8 films	UCR
0330	panoramic film	UCR

PREVENTIVE

1110	prophylaxis – adult	UCR
1120	prophylaxis – child	UCR
1203	topical application of fluoride (excluding prophylaxis) – child	UCR
1204	topical application of fluoride (excluding prophylaxis) – adult	UCR
1351	sealant – per tooth	UCR
0460	pulp vitality tests	UCR
0470	diagnostic casts	UCR
1510	space maintainer – fixed – unilateral	UCR
1515	space maintainer – fixed – bilateral	UCR
1520	space maintainer – removable – unilateral	UCR
1525	space maintainer – removable – bilateral	UCR
1550	recementation of space maintainer	UCR
4910	periodontal maintenance procedures (following active therapy)	UCR
9110	palliative (emergency) treatment of dental pain – minor procedures	UCR

COVERAGE B: BASIC SERVICES

RESTORATIVE

2110	amalgam – one surface, primary	$47
2120	amalgam – two surfaces, primary	$58
2130	amalgam – three surfaces, primary	$68
2131	amalgam – four or more surfaces, primary	$83
2140	amalgam – one surface, permanent	$52
2150	amalgam – two surfaces, permanent	$66
2160	amalgam – three surfaces, permanent	$79
2161	amalgam – four or more surfaces, permanent	$99
2330	resin–based composite – one surface, anterior	$61
2331	resin–based composite – two surfaces, anterior	$76
2332	resin–based composite – three surfaces, anterior	$92

2335	resin–based composite – four or more surfaces or involving incisal angle (anterior)	$116
2336	resin–based composite crown, anterior–primary	$116
2337	resin–based composite crown, anterior–permanent	$295
2385	resin–based composite – one surface, posterior–permanent	$70
2386	resin–based composite – two surfaces, posterior–permanent	$95
2387	resin–based composite – three surfaces, posterior–permanent	$121
2388	resin–based composite – four or more surfaces, posterior permanent	$142
2910	recement inlay	$45
2920	recement crown	$47
2930	prefabricated stainless steel crown – primary tooth	$114
2931	prefabricated stainless steel crown – permanent tooth	$134
2940	sedative filling	$48
2951	pin retention – per tooth, in addition to restoration	$25
6930	recement fixed partial denture	$67

ENDODONTICS

3110	pulp cap – direct (excluding final restoration)	$27
3120	pulp cap – indirect (excluding final restoration)	$27
3220	therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament	$73
3221	gross pulpal debridement, primary and permanent teeth	$90
3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$126
3310	anterior (excluding final restoration)	$308
3320	bicuspid (excluding final restoration)	$376
3330	molar (excluding final restoration)	$489
3333	internal root repair of perforation defects	$226
3346	retreatment of previous root canal therapy – anterior	$366
3347	retreatment of previous root canal therapy – biscupid	$438
3348	retreatment of previous root canal therapy – molar	$549
3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc)	$135
3352	apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc)	$125
3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc)	$139
3410	apicoectomy/periradicular surgery – anterior	$252
3421	apicoectomy/periradicular surgery – biscupid (first root)	$313
3425	apicoectomy/periradicular surgery – molar (first root)	$306
3426	apicoectomy/periradicular surgery (each additional root)	$173
3430	retrograde filling – per root	$84
3450	root amputation – per root	$193
3950	canal preparation and fitting of preformed dowel or post	$94

PERIODONTICS

4210	gingivectomy or gingivoplasty – per quadrant	$247
4211	gingivectomy or gingivoplasty, per tooth	$88
4220	gingival curettage, surgical, per quadrant	$129
4240	gingival flap procedure, including root planing – per quadrant	$295
4245	apically positioned flap	$355
4260	osseous surgery (including flap entry and closure) – per quadrant	$412

4263	bone replacement graft – first site in quadrant	$259
4264	bone replacement graft – each additional site in quadrant	$165
4270	pedicle soft tissue graft procedure	$341
4271	free soft tissue graft procedure (including donor site surgery)	$379
4274	distal or proximal wedge procedure (when not performed in conjunction with surgical procedure in the same anatomical area)	$258
4341	periodontal scaling and root planing, per quadrant	$108
4355	full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	$75
4920	unscheduled dressing change (by someone other than treating dentist)	$35

PROSTHODONTICS (REMOVABLE)

5410	adjust complete denture – maxillary	$37
5411	adjust complete denture – mandibular	$37
5421	adjust partial denture – maxillary	$37
5422	adjust partial denture – mandibular	$37
5510	repair broken complete denture base	$93
5520	replace missing or broken teeth – complete denture (each tooth)	$80
5610	repair resin denture base	$85
5620	repair cast framework	$130
5630	repair or replace broken clasp	$110
5640	replace broken teeth – per tooth	$78

ORAL & MAXILLOFACIAL SURGERY

7110	single tooth	$66
7120	each additional tooth	$60
7130	root removal – exposed roots	$74
7210	surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$118
7220	removal of impacted tooth – soft tissue	$134
7230	removal of impacted tooth – partially bony	$170
7240	removal of impacted tooth – completely bony	$214
7241	removal of impacted tooth – completely bony, with unusual surgical complications	$264
7250	surgical removal of residual roots (cutting procedure)	$118
7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	$193
7280	surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	$155
7281	surgical exposure of impacted or unerupted tooth to aid eruption	$132
7285	biopsy of oral tissue – hard (bone, tooth)	$120
7286	biopsy of oral tissue – soft (all others)	$102
7310	alveoloplasty in conjunction with extractions – per quadrant	$107
7320	alveoloplasty not in conjunction with extractions – per quadrant	$158
7340	vestibuloplasty – ridge extension (secondary epithelialization)	$442
7431	excision of benign tumor – lesion diameter greater than 125 cm	$333
7471	removal of exostosis – per site	$262
7510	incision and drainage of abscess – intraoral soft tissue	$80
7520	incision and drainage of abscess – extraoral soft tissue	$161
7960	frenulectomy (frenectomy or frenotomy)–separate procedure	$158
7971	excision of pericoronal gingiva	$110

9220	general anesthesia – first 30 minutes	$122
9221	general anesthesia – each additional 15 minutes	$64
9241	intravenous sedation/analgesia – first 30 minutes	$123
9242	intravenous sedation/analgesia – each additional 15 minutes	$61
9420	hospital call	$130
9440	office visit after regularly scheduled hours	$52
9610	therapeutic drug injection	$37
9910	application of desensitizing medicaments	$31
9911	application of desensitizing resin for cervical and/or root surface, per tooth	$31
9940	occlusal guard	$277
9951	occlusal adjustment – limited	$80
9952	occlusal adjustment – complete	$261

COVERAGE C: MAJOR RESTORATIONS

RESTORATIVE

2410	gold foil – one surface	$146
2420	gold foil – two surfaces	$207
2430	gold foil – three surfaces	$238
2510	inlay – metallic – one surface	$234
2520	inlay – metallic – two surfaces	$267
2530	inlay – metallic – three or more surfaces	$301
2542	onlay – metallic–two surfaces	$282
2543	onlay – metallic – three surfaces	$297
2544	onlay – metallic – four or more surfaces	$322
2610	inlay – porcelain/ceramic – one surface	$279
2620	inlay – porcelain/ceramic – two surfaces	$341
2630	inlay – porcelain/ceramic – three or more surfaces	$409
2642	onlay – porcelain/ceramic – two surfaces	$296
2643	onlay – porcelain/ceramic – three surfaces	$327
2644	onlay – porcelain/ceramic – four or more surfaces	$354
2650	inlay – resin–based composite – one surface	$307
2651	inlay – resin–based composite – two surfaces	$375
2652	inlay – resin–based composite – three or more surfaces	$450
2662	onlay – resin–based composite – two surfaces	$304
2663	onlay – resin–based composite – three surfaces	$372
2664	onlay – resin–based composite – four or more surfaces	$446
2710	crown – resin (laboratory)	$181
2720	crown – resin with high noble metal	$327
2721	crown – resin with predominantly base metal	$294
2722	crown – resin with noble metal	$327
2740	crown – porcelain/ceramic substrate	$343
2750	crown – porcelain fused to high noble metal	$335
2751	crown – porcelain fused to predominantly base metal	$314
2752	crown – porcelain fused to noble metal	$334
2780	crown – cast high noble metal	$339
2781	crown – cast predominantly base metal	$326
2782	crown – cast noble metal	$333
2783	crown – porcelain/ceramic	$332
2790	crown – full cast high noble metal	$338
2791	crown – full cast predominantly base metal	$319
2792	crown – full cast noble metal	$333
2932	prefabricated resin crown	$89
2950	core buildup, including any pins	$75
2952	cast post and core in addition to crown	$116
2954	prefabricated post and core in addition to crown	$89
2970	temporary crown (fractured tooth)	$83
2980	crown repair	$64

PROSTHODONTICS (REMOVABLE)

5110	complete denture – maxillary	$418
5120	complete denture – mandibular	$418
5130	immediate denture – maxillary	$451
5140	immediate denture – mandibular	$450
5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$294
5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$294
5213	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$445
5214	mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$444
5281	removable unilateral partial denture – one piece cast metal (including clasps and teeth)	$257
5650	add tooth to existing partial denture	$60
5660	add clasp to existing partial denture	$73
5710	rebase complete maxillary denture	$143
5711	rebase complete mandibular denture	$144
5720	rebase maxillary partial denture	$137
5721	rebase mandibular partial denture	$137
5730	reline complete maxillary denture (chairside)	$91
5731	reline complete mandibular denture (chairside)	$92
5740	reline maxillary partial denture (chairside)	$85
5741	reline mandibular partial denture (chairside)	$85
5750	reline complete maxillary denture (laboratory)	$127
5751	reline complete mandibular denture (laboratory)	$127
5760	reline maxillary partial denture (laboratory)	$124
5761	reline mandibular partial denture (laboratory)	$124
5850	tissue conditioning, maxillary	$50
5851	tissue conditioning, mandibular	$50
5875	modification of removable prosthesis following implant surgery	$125

PROSTHODONTICS (FIXED)

6010	surgical placement of implant body: endosteal implant	$650
6020	abutment placement or substitution: endosteal implant	$290
6056	prefabricated abutment	$195
6057	custom abutment	$255
6058	abutment supported porcelain/ceramic crown	$435
6059	abutment supported porcelain fused to metal crown (high noble metal)	$431
6060	abutment supported porcelain fused to metal crown (predominantly base metal)	$404
6061	abutment supported porcelain fused to metal crown (noble metal)	$422
6062	abutment supported cast metal crown (high noble metal)	$430
6063	abutment supported cast metal crown (predominantly base metal)	$396
6064	abutment supported cast metal crown (noble metal)	$419
6065	implant supported porcelain/ceramic crown	$448
6066	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$452
6067	implant supported metal crown (titanium, titanium alloy, high noble metal)	$448
6068	abutment supported retainer for porcelain/ceramic FPD	$435

6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$431
6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$402
6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	$421
6072	abutment supported retainer for cast metal FPD (high noble metal)	$429
6073	abutment supported retainer for cast metal FPD (predominantly base metal)	$399
6074	abutment supported retainer for cast metal FPD (noble metal)	$420
6075	implant supported retainer for ceramic FPD	$465
6076	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$455
6077	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$457
6078	implant/abutment supported fixed denture for completely edentulous arch	$888
6079	implant/abutment supported fixed denture for partially edentulous arch	$790
6210	pontic – cast high noble metal	$335
6211	pontic – cast predominantly base metal	$316
6212	pontic – cast noble metal	$325
6240	pontic – porcelain fused to high noble metal	$331
6241	pontic – porcelain fused to predominantly base metal	$307
6242	pontic – porcelain fused to noble metal	$328
6245	pontic – porcelain/ceramic	$345
6250	pontic – resin with high noble metal	$325
6251	pontic – resin with predominantly base metal	$311
6252	pontic – resin with noble metal	$313
6519	inlay/onlay – porcelain/ceramic	$354
6520	inlay – metallic – two surfaces	$239
6530	inlay – metallic – three or more surfaces	$269
6543	onlay – metallic – three surfaces	$298
6544	onlay – metallic – four or more surfaces	$302
6545	retainer – cast metal for resin bonded fixed prosthesis	$156
6548	retainer – porcelain/ceramic for resin bonded fixed prosthesis	$234
6720	crown – resin with high noble metal	$320
6721	crown – resin with predominantly base metal	$305
6722	crown – resin with noble metal	$316
6740	crown – porcelain/ceramic	$346
6750	crown – porcelain fused to high noble metal	$336
6751	crown – porcelain fused to predominantly base metal	$312
6752	crown – porcelain fused to noble metal	$332
6780	crown – 3/4 cast high noble metal	$323
6781	crown – 3/4 cast predominantly base metal	$329
6782	crown – 3/4 cast noble metal	$335
6783	crown – 3/4 porcelain/ceramic	$331
6790	crown – full cast high noble metal	$337
6791	crown – full cast predominantly base metal	$318
6792	crown – full cast noble metal	$331
6970	cast post and core in addition to partial denture retainer	$117
6971	cast post as part of fixed partial denture retainer	$123
6972	prefabricated post and core in addition to partial denture retainer	$88
6973	core build up for retainer, including any pins	$74
6980	fixed partial denture repair	$77

COVERAGE D: ORTHODONTICS

8010	limited orthodontic treatment of the primary dentition	$509
8020	limited orthodontic treatment of the transitional dentition	$594
8030	limited orthodontic treatment of the adolescent dentition	$733
8040	limited orthodontic treatment of the adult dentition	$895
8050	interceptive orthodontic treatment of the primary dentition	$685
8060	interceptive orthodontic treatment of the transitional dentition	$439
8070	comprehensive orthodontic treatment of the transitional dentition	$1,473
8080	comprehensive orthodontic treatment of the adolescent dentition	$1,481
8090	comprehensive orthodontic treatment of the adult dentition	$1,523
8210	removable appliance therapy	$241
8220	fixed appliance therapy	$280
8660	pre–orthodontic treatment visit	$92
8670	periodic orthodontic treatment visit (as part of contract)	$80
8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	$72

WHAT IS NOT COVERED

The following dental services are not covered and will not be paid:

- Services performed solely for cosmetic reasons;
- Services not performed by or under the direction of a dentist, including those services rendered by denturists/denturologists.
- Replacement of a lost or stolen appliance;
- Replacement of a fixed partial denture or removable complete or partial denture within five years from the date it was originally put in unless:
  (a) the replacement is necessary due to the extraction of natural teeth or you receive a new complete denture (maxillary or mandibular) that is opposite the one you currently have.
  (b) the fixed partial denture or removable complete or partial denture, while in the mouth, has been damaged beyond repair as a result of an injury received by you or your eligible dependents while covered by the plan.
- Replacement, at any time, of a fixed partial denture or removable complete or partial denture which meets or can be made to meet commonly held dental standards of functional acceptability;
- Appliances or restorations, other than complete dentures, whose main purpose is to change or correct your bite or stabilize teeth that have become loose because of gum disease;
- Cosmetic work to your bicuspids and molars (back teeth);
- Special complex attachments for removable partial dentures;

- Instruction for plaque control or oral hygiene;
- Bite registrations;
- Splinting;
- Services which do not have uniform professional endorsement;
- Services which are not payable under the section entitled "General Limitations";
- Services provided after your coverage ends except as described under "Extension of Benefits" on Page 5.

All claims must be submitted within one year from the date the service was performed or they will not be paid.

GENERAL LIMITATIONS

No benefits will be paid for expenses incurred:

- For occupational accidents;
- For sickness covered by Workers' Compensation;
- That are in any way reimbursable through any public program;
- For confinement or treatment received in a U.S. government owned or operated hospital;
- For charges which you or your dependents are not legally required to pay;
- For charges which would not have been made if coverage did not exist;
- For charges in excess of what is reasonable and customary (for Coverage A dental services);
- For unnecessary care or treatment;
- To the extent that payment under this plan is prohibited by any law to which you or your dependents are subject at the time expense is incurred;
- To the extent that the expenses are in any way reimbursable through "no fault" vehicle insurance;
- To the extent that the expenses are payable under any other insurance plan.
- Sealant benefit includes the application of sealants to caries-free (no decay) and restoration-free occlusal, buccal, and/or lingual sur faces of permanent molars only.

LIMITED BENEFIT FOR TEETH MISSING ON COVERAGE DATE:
Payment for covered dental expenses incurred for the replacement of teeth that are missing on the date coverage becomes effective will be 50% of the amount normally payable. After coverage has been in effect for 24 continuous months, this restriction will not apply.

COORDINATION OF BENEFITS

If you or your eligible dependents are covered under different group dental benefit plans, you can file for reimbursement under both plans.

If you file for reimbursement under both plans, the Plan Administrators will coordinate the benefits so that you will receive the maximum amount allowable. However, that amount will never exceed 100% of your covered dental expenses.

If a husband and wife have two different dental insurance plans that cover their children under both, the parent whose birthday comes first in a calendar year must file a claim under his or her insurance first. This is a commonly held insurance law known as “the birthday rule”.

HOW TO FILE YOUR DENTAL CLAIM

- You are assured of receiving full benefits under this dental plan if you visit a Participating Dentist. A Participating Dentist is a dentist who is under contract with the Claims Administrator. For a list of Participating Dentists, please contact your Personnel Officer or the Employee Benefits and Wellness Division in Montpelier.
- When you visit your dental office, show your I.D. card. If you are using a Participating Dentist, the office will file the claim directly with the Claims Administrator for you. In addition, a Participating Dentist will not charge at the time of treatment for covered services. However, they may request payment for the non-covered services.
- Once the claim is processed, payment will be sent directly to the Participating Dentist. A Notification of Benefits form (record of payment), will be sent to you. It will show the amount(s) paid to the dentist, and the remaining amounts, if any, which you may owe the dentist.
- If you visit a Non-Participating Dentist, you should bring a claim form with you for them to complete. Claim forms are available from your Personnel Officer or the Employee Benefits and Wellness Division. Payment for services will be made directly to you. You are then responsible for payment to the dentist.
- If you visit a dentist outside the tri-state area of Maine, New Hampshire and Vermont, payment will be made directly to the dentist unless it is noted on the claim form that you should be reimbursed. Claim forms are available from your Personnel Officer or the Employee Benefits and Wellness Division.

DEFINITIONS

Acrylic - A type of plastic used for dentures and some kinds of crowns.

Bitewing x-ray - An x-ray showing exposed portions of back teeth. Primarily used for early detection of hidden decay between teeth.

Fixed Partial Denture -
Abutment - Tooth or teeth on either side of missing teeth which are used as support for a fixed partial denture.

Fixed partial denture - A non-removable replacement of a natural tooth or teeth. It is cemented to natural teeth on either side which are used as abutments.

Removable partial denture - A partial denture normally held by clasps to natural teeth, permitting removal as desired.

Pontic - An artificial replacement of a missing tooth; part of a fixed partial denture.

Caries - Tooth decay

Cavity - Portion of a tooth destroyed by decay. Requires filling or sometimes more extensive treatment.

Crown - A denture restoration usually covering the whole exposed (coronal) portion of a tooth. Most often made of porcelain, gold or acrylic. Frequently used to restore a badly broken tooth.

Denture - A removable replacement for a natural tooth or teeth.
Full denture - A denture replacing all maxillary or all mandibular teeth, or both.

Partial denture - A denture replacing some, but not all, of the maxillary or mandibular teeth.

Endodontics - Treatment of diseases within the tooth, primarily root canal therapy.

Extraction - The removal of a natural tooth.

Filling - Material used to fill a cavity. Inserted in a tooth as opposed to covering it (crown).

Amalgam - One of the most common filling materials; usually soft silver which hardens after it is packed into the cavity.

Gold inlay - A cast gold filling made to fit a tooth cavity and then cemented into place.

Porcelain inlay - A baked porcelain filling used primarily in front teeth where appearance is important.

Surface - A term which refers to one of the five sides of a tooth. A one-surface filling is inserted in only one surface of a tooth; a two-surface filling is one which includes two adjoining surfaces of the same tooth in a single filling.

Fluoride - A chemical used in preventing tooth decay.

Gingiva - Soft tissue adjacent to the teeth; gums.

Gingivectomy - Cutting out diseased, dead gum tissue around the teeth so that fresh, new tissue will grow.

Impaction - A tooth partly or wholly buried under the gum by bone or tissue.

Occlusion - The contact position of the teeth when upper and lower jaws are closed; sometimes called "bite."

Oral surgery - Surgery of the oral mouth cavity, including teeth, tongue, neck, etc. May be dental or non-dental in nature.

Orthodontics - Teeth straightening or repositioning.

Osseous - Pertaining to the bone.

Periodontics - Treatment of diseases of the gum and tissue around the teeth.

Prophylaxis - A procedure to clean the teeth by scaling and polishing.

Prosthodontics - Artificial replacement of natural teeth; fixed and removable full and partial dentures.

Pulp - The soft tissue inside the crown and roots of a tooth composed of nerves, blood vessels and other tissue.

Pulp capping - Additional protection for exposed pulp when a deep cavity is being treated.

Restoration - A filling or crown which restores a natural tooth.

Root - The part of the tooth imbedded in the bone of the jaw.

Root canal therapy - Treatment of the pulp of a tooth.
Apicoectomy - Surgical amputation or cutting off of a portion of the root of a tooth.

Extirpation - Removal of pulp from a tooth and replacement with a filling material.

Pulpotomy - Amputation of the coronal portion of the pulp of a tooth; usually done on children.

Space maintainer - An appliance to keep space from closing after loss of a temporary tooth so that the permanent tooth will have room to grow.

- NOTES -

- NOTES -

- **NOTES** -

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State of Vermont
Employee Benefits and Wellness Division
Department of Personnel
56 East State Street, Drawer 20
Montpelier, VT 05620-5601